Best Practices to Avoid Medicare Denials

Ralph Wuebker, MD
Chief Medical Officer
Executive Health Resources

Agenda

• Overview of current audit environment and contractors

• Concurrent and appeal best practices

• Common documentation errors and recommendations
Today’s Audit Environment

- If you are treating patients and submitting claims, you will be audited
- It is about how the contractors interpret the regulations:
  - The regulations haven’t changed
  - The procedures haven’t changed
- Providers must appeal or the contractors’ interpretations become the new standard
  - Determinations based solely on screening criteria
  - Timing as sole determining factor (e.g., there is no 24-hour rule)
- The solution is NOT to make all prepayment reviewed cases ‘observation’
- Appeal cases that are inappropriately denied

Governmental Audit and Fraud Fighting Entities and Initiatives

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Best Practices To Prevent Denials

Review Cases Concurrently

Recognize that success is attained by using consistent, daily tactics:

1. Case Management applies **current, strict** admission criteria to 100% of medical cases placed in a hospital bed, plus documents this review in an auditable format
2. ALL cases that do not pass criteria (regardless of admission order status) are referred to a Physician Advisor who is an expert in CMS rules and regulations and clinical standards of care
3. The Physician Advisor:
   - reviews the case
   - speaks with admitting physician, when needed
   - makes a recommendation based upon UR Standards
   - documents the decision in an auditable format on the chart (or in UR documentation)
4. Attending physician changes the order, as appropriate
5. Should run 7 days a week/365 days a year
UR Staff Screening Criteria Review: ‘Keys to Success’

• Consider use of screening criteria that are recognized by your intermediary
• Apply screening criteria to 100% of FFS Medicare cases
• Ensure UR staff use screening criteria appropriately
• Inter-rater reliability testing to ensure appropriate use of criteria and valid decisions
  – Standardized case
  – Audit by case type
• Regular recurring education in the use of screening criteria
  – Especially in the case of UR staff turnover
• Ensure all cases that require secondary physician review are referred to a Physician Advisor for secondary physician review
  – Timeliness is key

Physician Review: ‘Keys to Success’

• Team
  – Almost impossible for one person to handle the volume
  – Requires different skill sets and knowledge bases
• Content
  – You cannot depend on the PA to “use their medical judgment” or opinion.
  – Must provide ‘library’ of evidence-based outcomes research across major diagnostic areas for decision making to be consistent and defensible
  – Without clinical references, cases will be hard to defend. Remember, the contractor also has a physician on staff.
• Training
  – Physician must be trained in medical management, CMS rules and regulations, and the evidence-based medicine mentioned above
• Quality Assurance
  – Best practice is a real time Q/A process to ensure highest quality of reviews
‘Top 10’ DRG Overturn Rates

1. DRG 247: Perc Cardiovasc Proc w Drug-Eluting Stent w/o... – Permanent program overturn rate of 98%
2. DRG 313: MED - Chest Pain – Lowest overturn rate of the Top 10, by volume, with a 93% win rate

Three-Tiered Tactical Approach to RAC Appeals

- All reviewed cases and appeals should be designed and written to prepare for the ALJ level of appeal
- Your argument must address three key components to have a high likelihood of success:
  - **Clinical:** Strong medical necessity argument using evidence-based literature
  - **Compliance:** Must demonstrate a compliant and consistent process for certifying that medical necessity was followed
  - **Legal:** Want to demonstrate, when applicable, that the auditor has not opined consistent with the SSA and other regulations
CMS Response to RAC Problems

If appeal within 30 days – NO Recoupment

If appeal within 60 days – NO Recoupment

ALJ Level of Appeal

- Most overturns are achieved at ALJ

- Key Observations
  - ALJ hearings are as varied as the ALJs themselves

- AXIOM: when you have seen one ALJ hearing, you have seen one ALJ hearing
  - Different ALJs have different styles, and, as a result, often place different demands on the appellant
  - Preparation and experience are of paramount importance

- NEW DATA: 80% of contractors now have a physician or attorney attend the hearing
Establishing “Medical Necessity”

- Documentation is the difference
  - Explicitly detail why the care provided was medically necessary in the inpatient setting
- The critical factor:
  - The judgment of the admitting physician with reference to the guidance of the Medicare Benefit Policy Manual and other CMS Manuals
- Citation to relevant medical literature and other materials
  - Utilization management criteria, local and national standards of medical care, published clinical guidelines, and local and national coverage determinations may be considered

Common Documentation Problems

- **Using a symptom rather than a diagnosis for the impression or assessment**
  - N/D/V vs. bowel obstruction
  - SOB, chest pain, headache, back pain
  - Listing the diagnosis as an intractable symptom (vertigo, abdominal pain, vomiting) without noting the potential diagnosis
- **Using a lab value or treatment plan with no diagnosis**
- **Documentation for medical necessity is different than documentation for billing level or coding**
Common Documentation Reasons for UM Staff to Call Attending Physicians

- Limited or no physician documented info (consult, ED note or H & P) several hours after “admission”
  - Only information available is a list of symptoms/labwork/Interqual® evaluation
- No plan of care or clear impression in the H & P
  - Common with mid-level providers
- OP note/H & P for procedures that doesn’t address or include any risk from past medical history
  - Frequently occurs from using office notes as history and physical
- Lack of discharge summary for a readmission review and no mention of stability on discharge/return to baseline in the discharge note
- Continued stay review that doesn’t include the current progress note or orders to indicate why the patient requires continued acute care following stabilization
- To ensure the physician order matches the CM determination/billing status prior to discharge for billing concordance

Common Vulnerability: Electronic Health Record

- All data is recorded but in different areas of the chart
- Find ways to ‘connect the dots’ for auditors
  - Demonstrate a consistently followed Utilization Review process in record
  - Find a way to include CM notes in record
  - Ensure physicians are demonstrating thought processes and detailed assessments of risk factors in their documentation somewhere in record
    - Physician impression/assessment dialogue box can be helpful
- Watch for COPY/CUT/PASTE
Best Practice Summary

• Demonstrate a consistent Utilization Review process for every patient
• Educate medical staff on documentation practices to avoid future technical issues
• Hospitals need to be prepared to defend their decisions and advocate for their rights

Remember…

• If you are treating patients and submitting claims, you will be audited
• Not all auditors are created equal
• Significant variation in interpretation of regulations by contractors
• Providers must appeal or the contractors’ interpretations become the new standard
Questions?

Ralph Wuebker, MD, MBA
drwuebker@ehrdocs.com

Private Contractor Actions:
RACs, Z-PICs, etc.

Thomas Beimers
Agenda

• Today’s Audit Environment
  – Government Fraud Fighting Initiatives
  – Scope and Purpose of Contractors

• Overview of Medicare Auditors
  • Preparing for and Responding to Record Requests
    – Clinical Considerations
    – Defenses

• Best Processes for Success

• Lessons Learned

By The Numbers

• Scope of Problem
• Recoveries
Issues with Government Audit Contractors

- OIG Reports
- GAO Reports
- Provider Criticisms
- CMS Response (Myths Document)

Fiscal Intermediary/Carrier/MAC

- Fiscal Intermediary (e.g., Noridian) processes Part A claims
- Carrier (e.g., Wisconsin Physician Services) processes Part B claims
- FIs and Carriers replaced by Medicare Administrative Contractors (MACs)
- Round 2 Procurement process is ongoing
- Purpose: To process Part A and Part B claims correctly
Fiscal Intermediary/Carrier/MAC

• Types of Reviews:
  – Automated Prepayment Reviews
  – Routine Prepayment Reviews
  – Complex Review
    • Requires medical record review
    • Focused on a specific provider
      – There’s a reason they’re looking at you – you’re an outlier!
    • Focused on a specific service
      – Service-specific reviews are posted online
  – 30 days allowed to submit records in response to an Additional Documentation Request (ADR)

Fiscal Intermediary/Carrier/MAC

• Preparing for Prepayment Reviews
  – Compliance should be immediately involved
  – Track status of all prepayment reviews (“probes”)
  – Understand why you’re an outlier
  – Review current processes and documentation practices
  – Consider putting a hold on claims
  – Review records before they go out the door

• Claims Subject to Review
  – Any claim submitted in past year
  – Any claims submitted in past four years for “good cause”
Fiscal Intermediary/Carrier/MAC

- Current law places limits on prepayment reviews that can be conducted by Medicare Administrative Contractors (MACs)
  - Random prepayment reviews can only be conducted to develop contractor-wide or program-wide claims payment error rates
  - Non-random prepayment reviews can only be conducted on a provider or supplier following
    - identification of an improper billing practice, or
    - a likelihood of sustained or high level of payment error (i.e., the same standard that permits the use of extrapolation)

- 2010 law repealed limitation on the use of prepayment medical reviews by MACs
Recovery Audit Contractor (RAC)

• **Purpose:** To identify and correct improper payments
• **Identity:** Contractors and sub-contractors

**Scope of Review:**
- Part A and Part B fee-for-service claims paid since October 1, 2007
- Cannot review claims paid more than three years ago
- Healthcare Reform expands RACs to Part B, Part C, Part D, and Medicaid
- Issues pursued must be reviewed by an Issue Validation Contractor

Responding to the Record Request

• Limit on the requested number of records
  - 1% of all claims billed in previous calendar year divided into 8 periods per 45 days
  - Campus includes all entities with same Tax ID that share the first three numbers of a zip code
  - Limits are based on a provider’s claims volume
  - Request not to exceed 400 records per 45 days
  - Limit can be increased with a waiver from CMS
RAC Issues

• Types of Reviews
  – Automated
  – Complex

• New Issue Review Process
  – Requires CMS to review and approve issues the RAC wants to audit
  – Issues approved by region
  – Approved issues posted on contractor websites

RAC Approved Issue Websites

• Region A – Diversified Collection Services

• Region B – CGI

• Region C – Connolly Consulting

• Region D – HealthDataInsights
Z-PIC and PSC Contractors

- Program Safeguard Contractor (PSC)
  - Created in 1996 to conduct Medicare program integrity activities

- Zone Program Integrity Contractor (Z-PIC)
  - Successor to PSC program

Purpose: Dedicated to program integrity and handles such functions as audit, medical review and potential fraud and abuse investigations

- PSCs replaced with Z-PICs
  - Z-PICs cover an area covered by a MAC
  - Z-PICs also have access to Medicaid data
Z-PIC Functions

• Medicare data analysis (discovery, detection, investigation, and overpayment projection)
• Medical Review (post-payment medical review and medical review to support fraud case development – Part A and Part B claims review)
• Medicare fraud investigation and prevention
• IT Systems for case and decision tracking and data warehousing;
• Interface with the Medicare contractors, the medical community (outreach and education), and law enforcement

Z-PIC Process

• Review targets a specific provider for a specific issue
  – You are an outlier, and they are investigating fraud
• Auditors appear, often unannounced, asking to interview individuals and obtain copies of policies and procedures (in addition to records)
• Extrapolation frequently used
• Can make referral to OIG or DOJ if fraud is suspected
• Oversight: Get Law Department involved immediately!
  – Consider conducting a shadow audit under attorney-client privilege
Responding to the Record Request

• Stamp Date and Time Received
• Train staff on identities of contractors
• Ensure that staff are aware of deadlines to submit records
• Ensure contractor is sending to the correct person/address
• Identify any internal issues causing delay in receiving the requests

Responding to the Record Request (con't.)

• Document Management
  – Stamp number (Bates Stamp) on bottom of each page produced
  – Scan everything provided to contractor
  – Include a cover letter itemizing box contents: documentation or a CD
  – Send by certified mail or, if regular mail, complete an affidavit of service by mail
Responding to the Record Request (con’t.)

• Process Options
  – Treat as normal ROI request; HIM produces the records
    • Cost effective
  – Normal ROI process with some clinical review
    • Ensure entire record is copied
    • Include copies of NCD, LCD, coding guidelines CMS guidance?
  – Shadow review of all submitted records
    • Resource intensive
    • Allows for early identification of issues
    • Establishes priority for appeals

Responding to the Record Request (con’t.)

• Software to Manage Records Produced
  – Does it help to manage the process or just store records?
  – Does it work with all types of audits, not just RAC audits?
  – Does it interface with your HIM or billing system?
  – Can compliance, legal, and other departments access the data?
  – Is it capable of producing a ‘dashboard’ for senior management review?
Defenses

- 1-year limit on reopening claims
- Limitation of Liability (Section 1879 of the Social Security Act)
- No Fault (Section 1870 of the Social Security Act)
- Treating Physician Rule
- Qualifications of Staff
- NCD or LCD is unlawful
- Should at least be paid an APC rate - or some amount - to reflect the outpatient services provided
Defenses (con’t.)

• Reviewer Used the Wrong Standards
  – Coding clinic, LCD, NCD, other CMS guidance
  – Note: QIC and ALJ are bound by laws and regulations, NCDs, and Medicare rulings, but not by other CMS guidance (such as Medicare Claims Processing Manual or Transmittals)

• Reviewer Applied the Standards Incorrectly
  – Review Medicare Ruling 95-1 on medical necessity standards
  – Support argument with affidavit/testimony of physician
  – Include any evidence of community standard
  – Include any scientific articles that support your position

Special Appeal Issues

• Extrapolation
    • A Medicare contractor may not use extrapolation to determine overpayment amounts for recovery by recoupment, offset, or otherwise, unless the Secretary determines that -
      (A) there is a sustained or high level of payment error; or
      (B) documented educational intervention has failed to correct the payment error
Special Appeal Issues (con't.)

• Extrapolation Defenses
  – Methodology was flawed
  – Statutory limitation on extrapolation applies
    • Note: a determination by the Secretary of sustained or high levels of payment errors is not reviewable (by the District Court), but could be considered at lower levels
  – Another statistically valid sample from the same ‘universe’ of claims yields a different result

Questions

Contact information:

Thomas Beimers
Faegre Baker Daniels LLP
(612) 766-8856
Thomas.Beimers@FaegreBD.com